Massachusetts Health Care Task Force
Interim Report

Introduction

When the Massachusetts Health Care Task Force was convened earlier this year, its conveners asked that it produce an interim report in December, 2000 and a final report in December, 2001. Accordingly, the Co-Chairs of the Task Force, on behalf of the Task Force, submit this Interim Report summarizing the subjects that the Task Force has covered and presenting recommendations or policy options that have so far emerged from its work. In addition, this Interim Report outlines areas of inquiry that will be addressed in the coming year.

The Task Force was not instructed to propose definitive solutions to the problems that it identified in the delivery of health care in the Commonwealth. Its mandate was to find facts, to identify problems presented by those facts, and to advance for consideration by the executive and legislative branches possible solutions to the identified problems, setting forth the benefits and disadvantages of each possible solution.

The fact-finding function has been important in clarifying the basic conditions of the delivery of health care. The identification of problems, many of which are and were self-evident, has revealed the complex interrelationship of the problems that confront the patient, the provider, the insurer, and the government official. Some of the identified problems are beyond solution by state government action. Others are beyond short-term solution by anyone. There are others, however, that can be addressed, at least in part, by action taken to alleviate immediate concerns.

The recommendations in this Interim Report are focused in considerable measure on action to be taken in the short term. Broader, long-term proposals require further attention. The availability of essential health care for all, whether through insurance or otherwise, is a generally accepted goal.

One concern in advancing proposals for state government action is that various factors bearing on a problem (such as market forces, changes in the economy, federal government action or inaction) are constantly changing. The question then is whether, in such cases, proposed state action will clearly improve the delivery of health care in Massachusetts. That said, however, there are several recommendations for immediate action contained in this Interim Report that have broad support.

Four working groups have been meeting at varying times and paces over the last several months to discuss and analyze aspects of the health care system and to report, in draft form, their findings, policy options and recommendations to the Task Force for its discussion and elaboration. The working groups are focused on finance, access, quality and administrative simplification. This Interim Report summarizes significant findings and recommendations in those draft reports, which are attached in their entirety. Task Force members have been invited to submit written comments in response to this Interim Report, and their submissions are also attached or incorporated in this Interim Report.

Hospitals

In June, the Finance Working Group presented its preliminary report on hospitals. (Attachment 1)[1] Its principal findings concerning the state of Massachusetts hospitals are:

1. The financial condition of Massachusetts hospitals has generally deteriorated so that their operating results are among the lowest in the country.
2. Hospital cost increases in the last few years have outstripped more limited growth in revenue.
3. Medicare payment curtailments in the Balanced Budget Act of 1997 (BBA) have increased the significance of limited growth in revenue from other sources.

[1] Certain figures in the attachments to the Draft Report on the Financial Condition of Hospitals have been adjusted with data provided by the Massachusetts Hospital Association. The text of the draft remains the same.

4. The BBA changes hit Massachusetts hospitals' profit margins particularly hard because a disproportionately large share of Massachusetts patients, compared with other states, are covered by managed care payers, which currently pay hospitals less than their costs.
5. The BBA changes also heightened the significance of Medicaid payment levels that are considerably below the cost of the services hospitals provide to Medicaid enrollees.

The Finance Group also found some indication that the financial condition of hospitals was likely to improve as hospitals obtained increases in payments by private payers and if the federal government, recognizing that the financial impact of the BBA on hospitals exceeded projections, were to provide them some relief. In light of these possibilities, at the time of its preliminary report, the Finance Group did not recommend aggressive state intervention with respect to hospitals through actions such as significant Medicaid increases to approximate "cost" or the creation of a state rate setting system, but recommended instead a "watchful waiting" stance, which included a recommendation that the Commonwealth increase its capacity to (a) monitor the financial condition of hospitals, (b) develop a strategic intervention approach, and (c) plan for preservation of a safety net health care system (including preservation of needed providers and financing mechanisms for the poor, such as Medicaid).

In addition, the Finance Group found that:

1. Per capita expenditures for hospital care in Massachusetts exceed those in most other states and for the nation as a whole. A portion of this difference can be explained by the higher cost of labor in this area and care provided to out-of-state residents.
2. Massachusetts community hospitals' casemix (a measure of the severity of patient conditions being treated) is lower than the national average casemix for community hospitals, most likely reflecting the use of teaching hospitals in Massachusetts to treat conditions that are handled in community hospitals in other regions. In general, care

provided by teaching hospitals is significantly more expensive than care provided for the same condition by community hospitals.

3. Hospital outpatient department utilization in Massachusetts is approximately 32% above the average national rate of utilization.

In light of these findings, the Finance Group recommended that the state encourage the movement of some services to alternative, lower-cost settings, and that consideration be given to reducing teaching hospital capacity in the event such movement of services were successful.

In October, the Finance Group reported that financial difficulties at Massachusetts hospitals were continuing, and that the prospect of private rate increases and federal relief had not materialized significantly. (Attachment 2) Despite indications that the financial condition of some hospitals – particularly teaching hospitals – was improving somewhat, that improvement was not across the board nor was it substantial. Although insurers had raised premiums, the Finance Group had not seen any indication that much of those increased revenues had been passed on to providers. In addition, the federal government had not enacted a BBA relief package as anticipated. Finally, while the state had increased funding to hospitals through several appropriation vehicles enacted in the previous several months, Medicaid payment rates remained, in the aggregate, substantially below cost. Added to the revenue problem was the fact that expenses per patient have grown more rapidly over the last year than in the previous several years. In recognition of this situation, the Finance Group was concerned that residents of the Commonwealth could be at some risk in the short run of a deterioration in the quality of hospital services or of a reduction in access to such services.

In light of these findings, the Finance Group suggested that the state assume a more interventionist posture and that it consider two measures. The first and more long-term measure suggested was the creation of a permanent independent commission to evaluate the entire health care system and to make recommendations to both the legislature and the administration on means to improve the efficiency and stability of the system. The

commission would have a small number of members, would be independent, but would have no direct regulatory authority. Its functions could include: (1) monitoring the structure of the health care system and its effectiveness in preserving access to services across the Commonwealth; (2) recommending ranges of inflation factors to be used by payers in calculating periodic payment increases; (3) recommending ways of maintaining access to services over time and under variable circumstances, including contingency planning; and (4) recommending changes to make the system more efficient overall. Suggested models include the federal Medicare Payment Advisory Commission (MedPAC) and certain state-level bodies in Maryland and New York.

The second and more immediate, short-term measure suggested was the creation of a financial stabilization plan consisting of three components: (1) increases in the Medicaid rate and changes in rate calculation methods where appropriate (pending the outcome of a separate study of Medicaid payment rates); (2) a special fund for distressed hospitals (and probably other providers as well) funded by the state and by private payers; and (3) a long-term hospital reinsurance revolving loan fund created by an assessment on hospitals (after enough hospitals are in a position to afford such an assessment).

The Finance Group held two meetings to discuss these measures in which it invited Task Force members to participate and to make alternative proposals. One alternative proposal for state intervention would involve state regulation of health insurance premium increases and the portion of such increases to be passed along to providers. (Attachment 3) It was generally agreed that this proposal would involve a return to hospital rate setting in some form. There was no widespread support for that approach. Discussion of the Finance Group's two main suggestions included a number of suggestions for refinement and limitation of the recommended steps, and did not reveal opposition to the general concepts. Of course, proposals to include assessments on private payers and hospitals were somewhat more controversial and would have to be considered only if and when those institutions are in a sufficiently stable financial position to support such assessments. The Finance Group is continuing to develop those proposals into possible recommendations. At this time, they remain general in nature as outlined in the October

16 update. In addition, hospital representatives asked the Finance Group to examine the Uncompensated Care Pool (Pool) as an additional mechanism through which state action could alleviate hospital financial distress. The Finance Group agreed that changing Pool financing and operation is an alternative that it should explore. The Finance Group has begun examining the Pool and will continue to include the Pool in its upcoming discussions.

Nursing Homes

In July, the Finance Group presented its preliminary report on the financial condition of Massachusetts nursing homes. (Attachment 4) The Finance Group's findings included the following:

1. Massachusetts uses nursing homes more than the national average rate of use.
2. Massachusetts nursing homes are generally worse off financially than they were several years ago (although there is considerably variation within the industry) and are generally worse off than nursing homes in neighboring states.
3. Approximately 25% (14,000) of the nursing home beds in the Commonwealth are owned by corporations now in bankruptcy; all of these bankrupt corporations are large national chains. An individual facility may be profitable even when its owner is bankrupt.
4. Large-scale borrowing by chains to finance acquisitions of existing facilities has resulted in substantial increases in debt service costs and revenue requirements; administrative costs relating to chains' size and corporate structure have increased as well.
5. Many nursing homes have reported extreme difficulty in attracting and retaining qualified direct care staff in the current tight labor market.
6. Massachusetts nursing homes have become increasingly dependent on Medicaid, which pays rates that are not designed to yield a cushion to subsidize significant changes in conditions and that in some cases are lower than the cost a given facility may incur in providing care.

The Finance Group found that the financial condition of the nursing home industry is serious, that there is no reason to expect improvement soon, and that the potential for quality of care to deteriorate due to financial pressures and the difficulty in attracting and retaining staff is real and a cause for concern. Because Medicaid funding for alternative forms of long term care is limited, people without resources could have difficulty obtaining appropriate care in some circumstances. The Finance Group also found that because Medicaid currently pays for approximately 70% of nursing home residents in Massachusetts, it is clear that Medicaid must play a dominant role in resolving what appears to be an unstable situation.

The Finance Group recommended that short-term stabilization efforts, including increased Medicaid rates, should:

1. Focus on staffing, including function, availability, retention, licensing and professional development;
2. Ensure that additional state resources are tied to quality of care;
3. Audit nursing home expenditures to ensure that any special assistance funds are not being used inappropriately to pay creditors or excessive administrative costs;
4. Measure and report access to nursing homes and other long term care options by geographic region;
5. Develop strategies to increase local (i.e. in-state) control of nursing homes.

In addition, the Working Group on Quality recommended that bankruptcy of a nursing home should serve as a trigger to the state to conduct regular inspections of that nursing facility to ensure that it provides appropriate care to residents.

Finally, the Finance Group recommended that planning efforts in long term care should be coordinated with planning in related areas, such as housing and home health care, and suggested that new approaches could be developed through pilot programs.

Some Task Force members suggested that additional state resources should be focused more towards expanding community-based options for long-term care, in light of most people's desire to remain in the community, rather than in encouraging a facility-based system. Others pointed out that the existing facilities are home to many people who are dependent on the state for payment, that those facilities are in serious trouble, and that there is no current capacity to transfer facility residents to community-based settings on a large scale. Moreover, there will always be some people who require a level of care that can only be provided in a facility.

Since the discussion of this report by the Task Force, the Commonwealth has devoted increased funding to wages for direct care workers at nursing homes and to developing career ladders for such workers. The Task Force's discussion of nursing homes will continue as it addresses long term care more generally in the coming year. That discussion will consider findings and recommendations from an interagency effort to develop a five-year plan for long-term care pursuant to a gubernatorial executive order, and the work of the Vision 2020 task force led by members of the legislature.

Financial Conditions in the Insurance Market

In September, the Finance Group presented its preliminary report on financial conditions in the health insurance market. (Attachment 5) The group observed that many Massachusetts residents obtain health coverage through self-insured (or self-funded) plans offered by their employers, and that such plans are regulated federally under the Employee Retirement Income Security Act (ERISA) and are not subject to state insurance regulation. Of those Massachusetts residents that do obtain coverage through state-regulated insurance products (i.e., in which the carrier or Health Maintenance Organization (HMO) assumes the financial risk for providing covered services to enrollees), the majority are enrolled in one of the state's largest HMOs. Because the continuity and predictability of health coverage for a relatively large portion of Massachusetts residents depend on the financial stability of these plans, the group's report focused on those plans. Its findings include the following:

1. A large proportion of the population covered by employer-provided insurance is covered by managed care plans.
2. The market is dominated by a small number of locally-controlled nonprofit HMOs, which is unusual when compared to the rest of the country.
3. A substantial percentage of the market is self-insured or self-funded. Systematic data on this portion of the market are not collected by the state and are not available from other public sources.
4. Premiums in Massachusetts are higher than national averages, although there is disagreement over whether making certain adjustments to account for certain characteristics of Massachusetts and its health care system would allow for a more accurate comparison.
5. Profit margins are low, although this is reflective of national trends.
6. Reserves at health plans are low, compared with the size of the plans and standards applied in other jurisdictions.
7. Massachusetts has fewer explicit financial standards and requirements for HMOs in certain areas than do many other jurisdictions, and the Insurance Commissioner has no clear legal authority to review health plan activities in certain respects that could affect financial stability.
8. Massachusetts has low and decreasing rates of uninsurance.

Four major concerns guided the Finance Group's discussion: (1) the need for enhanced HMO financial strength, through increased reserves and positive operating results; (2) discomfort with the disparity between premiums paid by small groups and individual enrollees and premiums paid by large groups; (3) a belief that premiums in general should be "affordable;" and (4) a belief that payments to providers should be timely and adequate. The Finance Group acknowledged that these general concerns are in tension with one another and that too much emphasis on addressing any one of them may exacerbate problems involving one or more of the others. For example, while recent premium increases appear to be necessary to improve health plan solvency and to pay for the rising costs of direct care, those increases may also increase the number of people

without insurance. Similarly, the Group acknowledged that health plans are at the center of many pressures exerted by various parts of the health care system and its many stakeholders – employers' and other payers' desire to keep premiums affordable, providers' need for adequate payments, and consumers' desire for access to services and providers at low or no additional cost.

The report listed a number of specific problems and their probable causes, and outlined strategies for addressing them, focusing on short- or intermediate-term interventions rather than long-term, fundamental changes to the system. The Finance Group recommended that the Commonwealth pursue several strategies directed toward increasing the financial stability of health plans, recommending that (1) in general the Division of Insurance would benefit from increased and clarified authority and additional resources in the area of health oversight, (2) laws relating to that oversight should include strong, reasonable standards for financial soundness, (3) new statutory requirements should be developed cautiously with attention paid to their potential costs, and (4) administrative and reporting requirements be reviewed and streamlined where possible.

The Group's specific recommendations were to:

1. Enact legislation establishing minimum net worth and risk-based capital requirements, consistent with national standards.
2. Require that plans report financial results by line of business, that they file reports using statutory accounting rules as well as Generally Accepted Accounting Principles (GAAP), and that they report on ASO (Administrative Services Only) business and enrollment.
3. Explore approaches to increasing oversight of risk-sharing arrangements and risk-assuming providers to ensure that providers have the operational capability and the financial resources to manage the risk assumed and that the financial terms of the arrangement are reasonable.
4. Consider new mandates, including mandated benefits and reporting requirements, in relation to any premium increases they will require.

5. Enact legislation giving the Commissioner of Insurance authority to oversee certain major transactions of HMOs, such as sales of substantial assets, mergers, and expansion into other states.
6. Explore the possibility of requiring that premiums be certified as actuarially sound by an independent analyst.

Task Force members were generally supportive of the Working Group's approach, although several members expressed concern that health plans could not comply with new standards and requirements, given their low reserve levels. Others noted that any increases in minimum net worth requirements would need to be phased in over an appropriately long period of time in order to avoid a shock effect on premium rates. Some members expressed a concern that new requirements not increase administrative expenses for insurers. In addition, some Task Force members expressed a concern that despite large increases in premiums, a relatively small portion of the increases is being passed along to providers, and that therefore adequacy of payments should be looked at closely. Others, however, noted that costs in other sectors of the health care system that are also the responsibility of insurers (such as pharmaceuticals) are going up as well.

Quality

In October, the Working Group on Quality submitted a preliminary report to the Task Force. (Attachment 6) The Group on Quality concluded, among other things, that:

1. Quality means different things to different stakeholders at different times. Stakeholders' perceptions of quality can sometimes be in direct conflict, but the various dimensions of quality are definable and can be measured to address varying stakeholders' interests.
2. There is no direct correlation between health care spending and quality, and, therefore, the efficient allocation of available resources is more apt to improve quality than increased spending alone.

3. The usefulness of currently available quality information is questionable because provider-specific differences are buried in health plan averages and little is collected from the outpatient setting where increasingly more care is provided.
4. Research has shown that quality information has little impact on health plans', purchasers' or consumers' decisions.

The Group recommended that quality measurement, data collection and analysis and reporting of information be geared towards the provider-specific level, and that data should be collected and analyzed in a controlled and uniform way. The Group suggested that objective reporting may help "level the playing field" among providers, especially in cases where lesser known or lower cost facilities emerge as providing high quality care. In addition, the group recommended use of a definition of quality that acknowledges its many facets, but that places primary emphasis on the consumer's experience.

The Group also concluded that, even though the reporting of quality information has apparently had little impact on contracting decisions by health plans or purchasers, there is reason to believe that reporting of such information could have an impact on provider practices. This effect could lead to both positive and negative results. For example, some reporting may cause providers to adopt "best practices" and improve their processes for providing care. In other circumstances, however, certain kinds of outcome reporting could lead providers to be reluctant to treat high risk patients out of concern that a bad outcome, even if it arose from the patient's characteristics rather than from the quality of care provided, could be interpreted as a bad reflection on the provider. The Group observed that the evaluation of how quality information is used and the impact it has on decisions has not kept pace with the development and dissemination of that information.

The Working Group on Quality recommended that an appropriate role for government is to educate consumers so that they can distinguish between poor and good quality care. The Group found that most people do not use objective quality information and instead rely on friends and family regarding when and from whom to seek care. With the balance of medical technical knowledge weighing heavily on the provider side and the

dollar leverage in the hands of the health plan rather than the individual patient, consumers' ability to "vote with their feet" is severely limited. In some cases, employers' choice of health plan will also limit consumers' ability to select providers. Still, there may be value in educating consumers about quality and about the "record" of their providers.

Task Force members generally agreed with the Working Group's approach of focusing on the consumer, both for defining quality and for identifying the need for additional information. Some Task Force members suggested that, in developing recommendations or policy options, the Working Group should avoid focusing on increasing state regulation or inspection, which can imply a punitive orientation, and should focus instead on public-private collaborative efforts such as the Massachusetts Health Quality Partnership.

Access to Health Insurance

In November, the Access Working Group submitted its preliminary report on access to health insurance, the first of two aspects of access it would consider. (Attachment 7) The Group will report on access to care, particularly as it is affected by the financial health of hospitals and community service providers in various geographic regions, early next year.

Citing the results of a recent poll by the University of Massachusetts and the state's Division of Health Care Finance and Policy, the Access Group reported that the Commonwealth had seen a dramatic reduction in the number of uninsured residents over the last several years. That reduction is due primarily to the expansion of the MassHealth program and aggressive outreach efforts to increase enrollment in it, to our low unemployment rate and relatively higher income levels, and to the strong tradition of employer-provided health insurance in Massachusetts. Notwithstanding that success, there are areas worthy of more focused attention. For example, the Group highlighted the fact that minority groups are still disproportionately uninsured.

The Group noted that having health insurance facilitates access to care and that, therefore, extending the availability of insurance should continue to be a goal of the Commonwealth. Indeed, the Group noted that a person's insurance status affects the likelihood that he or she will seek health care services. It also observed, however, that lack of insurance is not an insurmountable barrier to receiving care in Massachusetts, as there are many programs in the Commonwealth that facilitate access to care for people who do not have insurance or the means to pay for their own care.

The Group reported on the many programs administered by the Commonwealth that either provide health insurance, such as MassHealth and the Children's Medical Security Plan, or pay for services directly, such as the many programs funded by the Department of Public Health and other agencies. Many of those programs cover or subsidize only particular services, often only for particular population groups. Finally, the Group discussed the role of the Uncompensated Care Pool as the Commonwealth's health care safety net and payer of last resort, as well as the care many providers give without any compensation at all.

The Access Group acknowledged universal health insurance as an appropriate goal, but was uncertain that this goal could literally be achieved absent a state-sponsored single-payer system for all residents of the Commonwealth, which it felt would involve far-reaching and complex change. The Group did not feel it could recommend such a fundamental change, particularly in light of the relative success Massachusetts has had in expanding insurance, but advised that proposals for this level of change did deserve separate and focused analysis.[2] The Access Group recommended that the Commonwealth continue pursuing an incremental approach towards extending the availability of affordable health insurance that would target different aspects of our health insurance and public program systems, with the goal of determining an optimal combination of reforms that together would increase access to health insurance. The

[2] Section 32 of chapter 141 of the Acts of 2000 established an advisory committee to arrange for and evaluate an independent analysis of the feasibility and fiscal implications of establishing a system of consolidated health care financing and delivery.

Group did not have the time or technical expertise to specify which combination of reforms should be pursued, but noted that the recent award to the Commonwealth of a grant from the federal Health Services Resources Administration's State Planning Grant Program would provide resources for this purpose.

Among the strategies the group recommended for further exploration, with financial analysis and additional information gathering, are:

1. Expanding MassHealth, by income level or category.
2. Combining and streamlining state programs, wherever possible, to reduce administrative complexity and confusion.
3. Consideration of alternative insurance product design, such as high-deductible policies with subsidies for low-income enrollees.
4. Tax credits or subsidies to employers or employees, or both, for the purchase of commercial insurance.
5. Enactment of mandates on employers to offer insurance or on individuals to obtain and maintain insurance.
6. Insurance regulation reform, such as revised rate banding requirements or changes to permissible product design, to facilitate the creation of more affordable insurance products.
7. Medical savings accounts and flexible spending accounts.
8. "Indirect mandates" by the Commonwealth requiring all its contractors to provide health insurance to their employees.

The Group suggested that pursuing several strategies at once was likely to be more successful than concentrating on one or two, because the circumstances of people without insurance vary widely.

Task Force members generally agreed with the Access Group's recommendation that the Commonwealth continue to pursue incremental ways to further reduce the number of people without insurance. Some Task Force members were less supportive of the Access

Group's suggestion that increasing consumer financial responsibility for care (for those consumers that have the financial means to bear that increased responsibility) is desirable or appropriate. Those Task Force members rejected the implication that removal of much individual financial responsibility through pre-paid health plans that require only low co-payments for services has led to inappropriate utilization of services. Although the Access Group did not assert such inappropriate utilization, it did suggest that educating consumers about health care costs is desirable. For example, educating consumers about the high cost of health care may increase the importance some of them ascribe to health insurance.

Administrative Simplification

The Administrative Simplification Group gave a preliminary report to the Task Force in December. (Attachment 8) For purposes of its work, that Group has defined "administrative simplification" as reducing the degree of complexity and improving the degree of accuracy in the exchange of information among providers, insurers, and employers engaged in the health care system. The Group has focused its discussions on data used in billing and payment systems, and its goal is to reduce the time involved in closing transactions among a number of parties, particularly by lessening the number of retroactive adjustments required. In addition, the Group hopes to reduce the degree of ambiguity currently inherent in many transactions, which has resulted in the inability to automate many transactions.

The Administrative Simplification Group has reported principles that will create the framework for its recommendations. The principles put forward by the Group are as follows:

1. Standard transactions should be electronically exchangeable among all providers, payers, and employers. The expectation should be that transactions will be submitted in electronic format. To the extent that this is not done, compelling reasons should be presented for the exception.

2. The degree to which manual intervention is required at any point in processing transactions should be reduced to levels comparable to other industries with complex financial transactions.
3. While electronic transactions will likely take the form of both electronic data interchange (also known as "EDI") systems and internet-based systems for the foreseeable future, we should especially support actions that facilitate a movement towards broadly available internet-based systems.
4. Consideration should be given to the special needs of small providers to enable and encourage their participation in electronic transaction systems.
5. The electronic transaction process should permit a variety of vendors and approaches to co-exist.
6. National standards for electronic transactions should be adopted, where possible, to facilitate participation by multi-state enterprises.
7. Systems for electronic transactions should comply with state laws that relate to medical record keeping and confidentiality of medical information.

The next step for the Administrative Simplification Group is to develop specific recommendations in support of these principles. Among the recommendations the Group is developing so far are the following:

1. Massachusetts, in its roles of provider, payer, and employer, should set an example for participation in electronic transaction systems and should use its influence to encourage its financial partners to do likewise.
2. While electronic transaction systems must comply with HIPAA requirements, those requirements leave a great deal of discretion for local implementation. Massachusetts should act as a convener to facilitate a common local interpretation of the national standards under HIPAA.
3. Legislation and regulations to promulgate administrative simplification should do just that, reducing administrative costs and improving the ease of transactions, rather than making them more costly and difficult to perform.

4. The use of financial and economic incentives, rather than punitive measures, can be a powerful force in facilitating the expansion of electronic transactions among parties in the state.
5. Massachusetts should request health care participants to submit data periodically that document the degree of progress in support of its goals for administrative simplification.

Task Force members agreed that better data transmission could yield administrative savings, and suggested that even more savings could be achieved by simplifying relationships among participants in health care – employers, payers, providers and consumers. Some Task Force members felt that there should be strong incentives to use the Internet wherever possible, as opposed to other forms of electronic communication. Other Task Force members remarked that lack of capital resources among providers could be an obstacle in planning for electronic communications.

The Course Ahead

In the weeks and months ahead, the Task Force will continue to discuss the issues and recommendations from the working groups summarized above to determine which, if any, should become recommendations of the Task Force. In addition, the Task Force will receive and discuss additional reports on a variety of topics. Those topics will include at least the following:

1. Emergency Department utilization.
2. The financial condition of community-based providers.
3. The Uncompensated Care Pool.
4. Workforce issues, including physicians, nurses and other direct care workers.
5. The role health care plays in the Massachusetts economy.
6. Recommendations or policy options to further administrative simplification.
7. Results of focus groups of practicing clinicians and questionnaires being developed by the Working Group on Quality.

8. Access to health services by region.
9. Special issues relating to mental health care, including access and finance issues.
10. Special issues relating to dental care, including access and finance issues.
11. The role of pharmaceutical costs and approaches to financing affordable prescription drugs.
12. The role of employers as major payers.
13. The role of the Determination of Need program.
14. Long term care planning, including efforts underway in agencies and the Vision 2020 Task Force.

In addition to discussing particular topics such as these, the Task Force will need to address certain more general and fundamental questions in the course of its discussions. There may be no agreement among Task Force members on answers to these questions. In fact, disagreement is to be expected. Among the important contributions the Task Force will make to the further development of health policy in the Commonwealth is the discussion by its members of these important matters on a regular basis with the state's highest political leadership. Those questions will include at least the following:

1. What is the appropriate role of competition among providers and insurers? Does Massachusetts have enough providers and insurers to enable competition to play an effective role? Should providers or insurers be maintained for competitive reasons, even if that requires intervention with taxpayer dollars?

2. What is the appropriate role of state health planning? Should the state determine which facilities are needed to preserve access to health services? If so, what agency, person, or group should be the decisionmaker? How would decisions about whether a particular provider is "needed" be implemented?

3. How much is too much to spend on health care in Massachusetts? At what point will our health care costs dissuade businesses from locating here?

Our hope and belief is that continued discussion of by the Task Force will illuminate the issues and assist in making the decisions facing the administration and the legislature as they take steps to try to stabilize, preserve and improve our health care system.